min vs. 23.3 min, -65%). **CONCLUSIONS:** Time savings associated with Dmab SC injection were seen for all outcome measures. Opting for Dmab SC injection instead of Zol IV infusion should free up the hospital capacity to treat more patients, and decrease patients' treatment burden in Italy.

PCN313

DESCRIPTION OF BASELINE CHARACTERISTICS OF PATIENTS PROVIDED CANCER CARE WITHIN A NOVEL COMMERCIAL HEALTH PLAN CANCER CARE QUALITY PROGRAM IN THE FIRST YEAR

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OBJECTIVES: The HIRE – Oncology contains clinical oncology data captured as part of the Cancer Care Quality Program (CCQP), a novel program by Anthem health plans designed to align reimbursement with evidence-based, cost-effective oncology treatment, that is integrated with administrative claims data in the HealthCore Integrated Research Database (HIRD). This study updates prior research describing the baseline characteristics of patients within oncology practices participating in the CCQP. **METHODS:** Breast, colon, and lung cancer patients from HIRE-Oncology were identified between 6/23/2014 and 3/6/2015 (Intake Period). Patients were characterized based on the earliest request to utilize chemotherapy and/or supportive care medications (Index Date) during the Intake Period; analyses included patients with ≥6 months of continuous pre-index eligibility. Baseline characteristics were stratified by cancer type/stage and included: pathology, biomarkers, health care costs, and Deyo-Charlson Index (DCI). **RESULTS:** A total of 2,206 breast, 554 colon, and 796 lung cancer patients were identified with mean(SD) ages and DCI's of 64(10), 56(10), and 61(9) and 5.6(3.2), 7.6(2.6), and 7.8(2.8), respectively. Stage distributions indicated the greatest prevalence with stage IV disease: 36%, 73%, and 74% among breast, colon, and lung cancers patients. Pathology results among lung cancer patients demonstrated 78% and 22% with non-small cell and small cell cancers, respectively. 36% of breast cancer patients were HER2 positive, 34% of lung cancer patients were detected with EGFR mutation, and 32% of colon cancer patients were detected with KRAS mutation among those reporting test results. Across all stages, total all-cause mean (SD) baseline health care costs were $51,430($58,567), $67,760($59,064), and $59,789($55,846) among breast, colon, and lung cancer patients, respectively. **CONCLUSIONS:** This updated analysis provides valuable initial insight into the demographic and clinical characteristics of patients within participating practices during the first year. HIRE-Oncology provides a comprehensive picture for commercially-insured oncology patients and baseline data for future program evaluation.

PCN314

ONCOLOGIST SUPPORT FOR AMERICAN SOCIETY OF CLINICAL ONCOLOGY (ASCO) CONSOLIDATED PAYMENTS FOR CANCER CARE MANAGEMENT IN THE UNITED STATES (US)

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OBJECTIVES: To assess physician support of the 2014 ASCO payment reform proposal, focusing on four components: 1) new patient payments- single payment for any new patient until treatment begins; 2) treatment month payments-each month the patient is treated; 3) active monitoring month payments-during months when the patient is not actively treated but receiving care and support; 4) transition of treatment payments-for a change in patient status during a month. **METHODS:** Medical-oncologists and hematologist/oncologists across the US, practicing for at least 2yrs and managing at least 20 patients, were randomly sampled to participate in a cross-sectional survey via a panel. **RESULTS:** 231 physicians participated (87% physicians, 13% medical directors; 67.5% hematologist/oncologists, 32.5% medical-oncologists). Mean practice duration:15yrs; 53% practice in an academic/community/Veteran's facility and 47% in group/solo private practice; geographic distribution: South:32%/Northeast:29%/Midwest:23%/West:17%. Only 7% rated the reimbursement climate as "excellent" (good:32%/satisfactory:42%/not very good:20%/bad:2%); 18% rated the financial status of their cancer program as "excellent" (good:41%/satisfactory:33%/not very good:7%/bad:<1%). Physicians reporting that they "strongly" or "somewhat" support the components of the 2014 ASCO proposal: 1) new patient payments:47%; 2) treatment month payments:57%; 3) active monitoring month payments:55%; and 4) transition of treatment payments:54%. Physician rating of "strong/somewhat support" based on perception of reimbursement climate (excellent/good vs. satisfactory/not very good/bad): 1) new patient payments:55%/42%; 2) treatment month payments:66%/51%; 3) active monitoring month payments:65%/48%; 4) transition of treatment payments:61%/50%. "Strong/somewhat" support based on perception of financial status of their cancer program (excellent/good vs. satisfactory/not very good/bad): 1) new patient payments:49%/44%; 2) treatment month payments:61%/52%; 3) active monitoring month payments:60%/47%; 4) transition of treatment payments:59%/47%. **CONCLUSIONS:** About half of the physicians in the study supported the components of ASCO's 2014 proposed payment reform, especially if they already considered the current reimbursement climate and financial status of the cancer program to be positive.

PCN315

G-BA DOES NOT ADJUST EVIDENCE REQUIREMENTS IN EARLY BENEFIT ASSESSMENT IN CASES OF PRE-DEFINED, EFFICACY-BASED CROSS-OVER DECISIONS IN ONCOLOGY TRIALS

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OBJECTIVES: In Germany, an early benefit assessment (EBA) by the Federal Joint Committee (G-BA) is compulsory for all new drugs. Pre-defined treatment switching, often called 'cross-over', is often seen in oncology clinical trials. Cross-over is usually implemented for ethical reasons, i.e. to ensure access to a beneficial treatment for all patients, but may confound data analysis by improving efficacy in the control arms. We aimed to analyse the impact of cross-over on evidence levels granted by the G-BA. **METHODS:** Oncology medicines with completed EBAs by 01 Jan 2015 were analysed for i) presence of cross-over in pivotal trials; ii) efficacy results before and after cross-over and iii) evidence levels granted by the G-BA (proof, indication or hint). **RESULTS:** Cross-over was frequent in oncology, concerning 14 of 28 EBAs (50%). For 6 of the 14 medicines, cross-over could be considered ethically required as significant differences in overall survival (OS) were demonstrated prior to cross-over. For most medicines, data on OS and progression-free survival were reported after cross-over (10/14 and 8/14, respectively). Significant differences in OS post-cross-over could only be shown for 2 out of the 8 medicines for which no such differences were demonstrated before cross-over. An evidence level of proof was granted by the G-BA for 3 out of the 14 medicines, all of which were orphan drugs, but none were granted for medicines with ethically required cross-over. **CONCLUSIONS:** The G-BA regards evidence standards as only partially fulfilled in cases of ethically required cross-over in oncology. Highly efficacious drugs with ethically mandated cross-over are therefore systematically disadvantaged with regards to the achievable evidence category, indicating a bias against innovation. Medicines with a demonstration of superior efficacy and subsequent ethically justified cross-over deserve an evidence level of proof.

PCN316

QUALITATIVE ASSESSMENT OF SOCIETAL PREFERENCES FOR MARKET ACCESS OF CANCER DRUGS

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OBJECTIVES: The need and price for cancer drugs will increase while budgets are becoming more constrained. Policy makers need to make hard choices about which drugs are worthwhile. Inclusion of societal preferences in resource allocation is emphasized by academic research and policy makers. This study qualitatively assesses societal preferences for market access of cancer drugs. **METHODS:** Focus group discussions (FGD) with members of the general population in Flanders (Belgium) were organized. Participants were recruited through flyers distributed in the University Hospitals Leuven and social media. First, the topic of budgetary constraints and resource allocation was introduced. Next, introductory statements based on ethical principles were discussed. Hypothetical scenarios were set up to ask people about characteristics of a patient, disease and drug that they would use to prioritize if there is only money to use/treat one of them. FGD were led by one researcher, video and audio recorded, verbatim transcribed and analyzed using thematic framework analysis. FGD were repeated until data saturation. Participants received a compensation of €20. **RESULTS:** Three FGD with each six participants were conducted in February 2015. The median age of participants was 43 years (22-65, N=18). When participants are asked to define criteria they would use to prioritize patients, they mention age and life style of a patient and severity of the disease. They prefer to treat the largest patient group with the best prognosis. Drugs would be prioritized by participants based on the effect on quality of life, side effects and treatment duration. **CONCLUSIONS:** Participants would like to maximize the benefits within a restricted budget, but conflicts between criteria such as prognosis and severity of disease crop up. Further research will quantify the relative importance and the trade-offs between criteria that society is willing to make through a discrete choice experiment.

PCN317

PRICE STRUCTURE ASSESSMENT OF SELECTED ONCOLOGY PRODUCTS IN CHINA, TAIWAN, SOUTH KOREA, BRAZIL, AND MEXICO

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OBJECTIVES: To understand the impact of supply chain and healthcare system structure on public price for oncologics in selected emerging markets. **METHODS:** Review of published price data and publicly available information from health authorities, WHO websites, peer reviewed and scholarly publications. Primary input from current payers and healthcare for validation and gap mitigation. **RESULTS:** In the selected countries, when comparing to the US pharmacy price as benchmark, oral targeted oncologics were priced lower than injectable oncologics. Brazil and the Mexican private sector saw the largest disparity with difference of approximately 40% between orals and injectables. Taiwan had the smallest difference between orals and injectables with only a 4% difference. China had the highest prices among the selected countries. In countries with both a public and private market, the prices in the public sector were always lower than those in the private sector. The ex-factory prices in the selected countries were much closer, with maximum 16% difference between lowest to highest price level. Brazil has the highest ex-factory price for orals with 72% and China has the highest for injectables with 77%. South Korea had the lowest ex-factory and pharmacy prices for both orals and injectables. **CONCLUSIONS:** The combination of no reimbursement, a regionalized approach to pricing, and a complex distribution chain has led to highest mark-ups at pharmacy level price in China among the selected countries despite having similar ex-factory prices. Due to tougher price negotiations in the public sectors, targeted oncology products enter the Brazil and Mexico markets in the private sector first then enter the public market which allows for greater the average price differential between public and private sectors. With universal healthcare systems in South Korea and Taiwan and international price referencing the price differences between orals and injectables and the mark up from ex-factory to pharmacy purchasing price is negligible.

PCN318

IMPACT ON TIME GAP BETWEEN APPROVAL AND REIMBURSEMENT OF TARGET THERAPY TO ADVANCED COLORECTAL CANCER

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OBJECTIVES: Three target therapies for advance CRC had been approved by TFDA since 2005; only two are under reimbursement now. Long reimbursement process had prevented advanced CRC patients from prescribing target therapy. This study is to use Cetuximab, the first reimbursed target therapy to evaluate the impact of